IN THE CIRCUIT COURT FOR SUMTER COUNTY, ALABAMA

JIMMY C. ACTON

PLAINTIFF,

V.

CIVIL ACTION NO. CV-96-98

R.J. REYNOLDS TOBACCO COMPANY, et al.,

DEFENDANTS.

****

DEPOSITION OF ARTHUR M. MARTIN, M.D.

Taken at Rush Hospital, 1314 19th Avenue
Meridian, Mississippi,
on Wednesday, February 10, 1999,
beginning at approximately 9:00 a.m.

****

REPORTED BY:

MELISSA L. BURNHAM, CSR, RPR
Certified Shorthand Reporter
Registered Professional Reporter
Notary Public

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STIPULATION

It is hereby stipulated and agreed by and between the parties hereto, through their respective attorneys of record, that this deposition may be taken at the time and place hereinbefore set forth, by MELISSA L. BURNHAM, Court Reporter and Notary Public, pursuant to the Rules;

That the formality of reading and signing is specifically NOT WAIVED;

That all objections, except as to the form of the questions and the responsiveness of the answers, are reserved until such time as the deposition, or any part thereof, may be used or sought to be used in evidence.

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(EXHIBIT NOS. 1 AND 2 WERE PREMARKED FOR THE RECORD.)

ARTHUR M. MARTIN, M.D.,

having been first duly sworn,

was examined and testified as follows, to-wit:

EXAMINATION

BY MR. ESDALE:

Q. Good morning, Dr. Martin.

A. Good morning, sir.

Q. Would you state your name for the record, please.

A. Arthur Morrison Martin, Jr.

Q. And where is your office located?

A. In Rush Hospital, Meridian, Mississippi.

Q. And what is your specialty?

A. Pathology.

Q. I'm going to show you what's been marked as Exhibits 1 and 2. Have you seen either one of these documents?

A. I don't know that I've seen Number 1. I believe Number 2 is the -- yes, is the expert witness disclosure and my curriculum vitae.

Q. Okay. For the record, Number 1 is the deposition notice for this case.

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A. I haven't seen that.

MR. STUHAN: For the record, I haven't seen Exhibit 1 either before today.

Q. (Mr. Esdale Continued): Do you have a file on this case, Dr. Martin?

A. Yes, sir.

Q. Did you bring that with you?

A. No, sir.

Q. Do you have it here in the hospital?

A. Yes, sir.

Q. What all is contained in that file?

A. A time sheet, two pages of notes, and photocopies of certain parts of the medical record.

Q. When it's convenient, is it any problem for you to get that and bring it down here?

A. How much of it do you need?

Q. Well --

A. I mean, if you just need the notes, we've got the notes here.

Q. Okay. You've got the notes here?

A. Yeah.

Q. All right.

A. The rest of it is just -- is specific

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photocopies of existing medical records on this man.

Q. Okay.

A. Those are -- those are the only two pages of notes that I have on it.

Q. Okay.

MR. ESDALE: Let me get these marked.

(EXHIBIT NO. 3 WAS MARKED FOR THE RECORD.)

MR. ESDALE: Give me just a second and let me look over this.

Q. (Mr. Esdale Continued): Let me just do this: If I can get you, real quick, to -- let's go through these notes.

A. Okay.

Q. And if you can just start at the top and kind of tell me -- of page one, we'll just call the one with the --

A. Yeah.

Q. -- exhibit sticker on it page one. Just go through those and tell me, in your mind, why you took these notes; in other words, if they're important to you or just general background information.

A. The first page is dated November 17th, 1998, was when Mr. Duncan and Mr. Ingram came for

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a consultation conference with me to see if I would review the -- this case with them. And in doing so, I believe it was probably Mr. Duncan who simply began to give me the background of the patient and who he was and what his -- you know, a brief synopsis of his medical record. All I was doing was just taking notes so that I could remember it, because --

Q. Had you ever met Mr. Duncan before?

A. Yes.

Q. Okay. What is his full name, if you know?

A. Thomas.

Q. Thomas Duncan?

A. Thomas something Duncan. He's present in the room.

Q. Oh, okay.

A. Attorney for Shook, Hardy & Bacon.

Q. All right.

A. He brought -- he brought the case to me. And this -- the first page represents my notes of what he was saying about the medical history and past history of the patient, the plaintiff.

Q. Okay.

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MR. ESDALE: I'm sorry. I apologize. I was thinking -- for some reason, I thought your -- I've talked to too many lawyers lately. Thomas Duncan?

MR. DUNCAN: Yeah.

MR. ESDALE: I'm sorry, Tom -- Mr. Duncan.

Q. (Mr. Esdale Continued): I called him Mr. Nelms when he walked in.

A. Well, no, he's still -- he's still Mr. Duncan.

Q. Yeah.

A. But that's what -- that's what this first page represents, is my brief notes of the medical history, pertinent medical history of Mr. Acton.

Q. Okay. And who is Mr. Ingram? Do you know?

A. Ingram, he's with Womble? Who's Ingram with?

Q. If you know. That's all right if you're not sure. You think he's with Womble Carlisle?

A. Yeah, I think that's who.

THE WITNESS: You weren't here that

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time, were you?

MR. STUHAN: I was not.

THE WITNESS: No, you were not.

A. I think he's with Womble Carlisle.

Q. Okay. All right. Go ahead. I'm sorry.

A. But that's all this first page represents, is just a brief synopsis of the medical history, the background of the patient.

Q. All right. And that was on November the 17th --

A. Yes, sir.

Q. -- of 1998?

A. Yes, sir.

Q. Did -- was that the first meeting that you had with anyone regarding this case?

A. Yes, sir.

Q. Had you ever worked with Mr. Ingram or Mr. Duncan before?

A. What did you mean by "work"?

Q. Had you ever consulted with them?

A. Yes.

Q. On how many occasions?

A. One or two.

Q. Do you recall when that was?

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A. Within the last year.

Q. Were they on cases other than this case?

A. Yes, sir.

Q. Were they on -- regarding tobacco and health issues?

A. Yes.

Q. Do you have any idea what the style of those cases was?

A. One of them is Carney versus Philip Morris, and Mr. Ingram happened to be present for a deposition that I gave in that. Another attorney with Shook, Hardy & Bacon was the principal attorney that I had met with.

The other one is -- I forget the fellow's name. It was the Marlboro man in North Carolina, Womble Newcolm? Is it -- Newcolm versus Philip Morris or something like that. I don't -- I don't know precisely off the top of my head.

Q. Are those the two other cases you've consulted with any of the tobacco companies regarding --

A. Oh, no. There are other -- there are other cases that -- with other attorneys and other tobacco companies.

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Q. Okay. Do you -- do you have a list of those?

A. Yes, sir.

Q. Or do you keep a list?

A. Yes, sir.

Q. Is that something you can furnish to your attorneys?

A. Sure.

Q. Do you have any idea, just for purposes of this deposition, how many cases there are that you're working with the tobacco companies on?

A. Oh, past and present, the total is 11.

Q. Okay.

A. But I would say maybe five of those are active. The rest of them are -- maybe six are active, and the other five are inactive.

Q. Okay. Am I -- is it -- well, let me back up just for a second. The -- this was the first meeting that you had on this case?

A. Yes, sir.

Q. At that first meeting, were you given any materials?

A. I was provided the microscopic slides from the case.

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Q. Other than that, anything else?

A. I didn't physically receive anything. I think I asked questions, and Mr. Duncan answered questions from the medical record.

Q. And that's what I'm getting at. All the information, I assume, then, contained on Exhibit 3, the first page, is information that was given to you by Mr. Duncan?

A. Yeah, is my representation of what I think he said.

Q. Okay. In other words, those are notes taken by you?

A. Right.

Q. Based on what he was telling you?

A. That's right.

Q. Okay.

MR. STUHAN: Graham, just to be clear, are you trying to make a point that the information came from Mr. Duncan as opposed to Mr. Ingram, who is also listed as present at that meeting?

MR. ESDALE: Well, I'll ask him about that.

A. I don't know which one.

Q. Okay. But I guess my point I'm trying

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to make is --

A. They were giving me -- excuse me.

Q. That's all right. The point I'm trying to make is, the information contained on that sheet came from the attorneys and not from any other outside documents -- at that time?

A. At that time. The information was provided at my request, "Tell me about the case."

Q. Okay.

A. I have -- before you can get into reviewing a case, you've got to know something about what the case is.

Q. Sure.

A. The material. And this was what was the summarization of Mr. Acton.

Q. All right. And then it's my understanding on November 17th you also were provided the pathology slides of Mr. Acton?

A. Yes.

Q. Did you review those on November the 17th?

A. Yes, sir.

Q. Let's move to page two of Exhibit 3. What are those notes?

A. That's my handwritten notes of what I

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saw in the microscope.

Q. On --

A. Of the pathology slides, which were the biopsies of the -- of the lesion in the lung, and the cytology smears.

Q. Okay. Were those notes made -- are they dated?

A. No, sir.

Q. Were they made on November 17th of '98?

A. Yes, sir.

Q. So those were notes you made at the first meeting and after your first viewing of the pathology, is that correct?

A. My recollection is that -- and this is -- I'm not real sure, but my recollection is that page one, I recorded as either Mr. Duncan or Mr. Ingram or both were providing me information about the nature of the case.

And page two, I think I recorded after they had left.

Q. But those are still --

A. Based on what I had just seen.

Q. Those were notes made contemporaneously with --

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A. Yes, sir.
Q. -- you reviewing the --
A. Yes, sir.
Q. -- pathology slides of Jimmy Acton?
A. Yes, sir. Yes, sir.
Q. Okay.
A. Not done some time later, but, you know, sometime that same day.
Q. While it was still fresh in your mind?
A. Yes, sir.
Q. When -- well, let me -- at the -- at that initial meeting, what were you asked, if anything, to do by Mr. Duncan and Mr. Ingram?
A. To look at the slides.
Q. And did they give you --
A. They didn't tell me -- they didn't tell me anything about the diagnosis. All I had was the history of the presentation and something about Mr. Ingram's background, as recorded on --
Q. You mean Mr. Acton's background?
A. Mr. Acton's, excuse me.
Q. That's all right.
A. Mr. Acton's background.
Q. Just wanted to make sure it's clear on the record.

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A. But they did not say anything about the slide except that it was -- it was the biopsy from the lung. That was all they said.

Q. All right. Now, I think I saw on your notes that they had provided you information that it had been previously diagnosed as a small cell carcinoma?

A. Yes.

Q. Okay.

A. You're right.

Q. Other than that, they just asked you to look at that?

A. Yes.

Q. And did they ask you to look at it at any certain time, or did they make -- let's just leave that --

A. It was -- it was right then.

Q. Okay.

A. While they -- while they were in the room.

Q. Oh, did you actually look at it with them in the room?

A. I looked at it by myself with them in the room.

Q. Okay. Did you tell them what you saw

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in the slides before making the notes that are page two of Exhibit 3?

A. So far as remember, yes.

Q. Is -- do you recall what you told them about what you saw in the pathology slides?

A. In substance, is what I've got recorded here.

Q. Okay. Did you look at the slides again to make those notes, or was that the only time you looked at the slides, on November 17th?

A. I looked -- I put them back on my microscope several times.

Q. That day?

A. That -- during that -- during that conference, yes.

Q. Okay. Did you look at them at any time after Mr. Duncan and Mr. Ingram had left?

A. They took them with them.

Q. Okay.

A. For the record, I looked at them again yesterday, but I -- they've not been in my possession.

Q. Have you looked at them at any time between November the 17th of '98 and yesterday?

A. No, sir.

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Q. Did you see anything different or in addition to what is recorded in page -- on page two Exhibit 3 when you reviewed the slides yesterday?

A. In substance, no.

Q. All right. Let's go through page two. Tell me --

A. All right. What -- the first part of page two is my notes referable to the biopsy, which is identified "S95-9068." And what I recorded that I saw was small fragments of markedly necrotic small cellular lesion, lots of karyorrhexis, k-a-r-y-o-r-r-e-x- -- r-r-h-e-x-i-s, suggestion of nesting of cells. No good preservation of lesional cells. Surface epithelium, where present, is intact, even area of ciliated pseudostratified columnar. And then small lesional capillaries are intact. I'm just -- all that is, is a description of what I'm visually seeing.

Q. Okay. All right. And that was the slide that you just told us about. Did you review another slide or additional slides?

A. The only other thing -- only other material available were a couple of cytology

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slides. And they're identified as cytol-95-5845. And what it has was blood and occasional clumps of suspicious small-to-medium sized cells, not clear-cut, meaning a clear-cut diagnosis is not evident.

And the rest of that was just, I think, in response to how would I have handled the case, and this is how I would have handled the case.

Q. And the rest of these notes, just for the record, read -- if I misstate that -- well, you just tell me.

A. All right. What I was recording was my recollection of what I had said that I would have -- how I would have handled the case had I had been the pathologist of record, since the diagnosis cannot clearly -- cannot clearly establish diagnosis based on available material.

So the course of action would have been to, one, request repeat biopsy. Short of that, to try to do immunohistochemical or special stains on the tissue available to see what additional information might be forthcoming, if any. And in that regard, I wrote out "LCA," which is leukocyte common antigen, chromagranins,

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cytokeratin, chirukian, etcetera, which is just a panel of stains that would have given me an opportunity to try to figure out what this lesion might be.

And then if not able to determine a specific diagnosis, refer to a reference laboratory for -- such as Mayo Laboratories in Rochester, Minnesota. And I put "etcetera." And "etcetera" means that if somebody wanted me to refer someplace else, I would have referred it someplace else. But this is a case that would have benefitted from referral.

Q. Do you, in your practice, refer pathology slides out for reference?

A. When they're unusual or not -- when you can't easily -- when you can't definitely establish a diagnosis, then I refer to someone with more experience.

Q. Have you, on occasion, referred slides out without doing any additional biopsies or testing?

A. Maybe. I mean, it would be hard to say, because what -- if we -- if we take a -- just presume a hypothetical case similar to this. If presented with a biopsy of something from a lung

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that looked like this, it, to me, is an unusual something, and they can't -- or won't go back and get a repeat biopsy.

I would rather -- prefer a repeat biopsy to obtain viable tissue, because this is not viable tissue. If they couldn't do that, then I try to do the special stains, again, as I just mentioned, to see if a particular pattern -- we're looking for a pattern in order to establish a diagnosis.

And if that were not forthcoming, then send it to somebody in the anticipation that -- at a regional medical center, there may be a pulmonary pathologist or someone who has an opportunity to see more unusual lung lesions than I would have an opportunity to see.

So that sequence of events would be followed whether it were as a hypothetical lung case or whether it was a lymph node that was unusual for a lymphoma or anything else that just didn't have a usual and customary presentation of something.

Q. So there's nothing else -- when you refer a slide out, there's nothing else they can do to it, they're just more accustomed to seeing

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different things?

A. I don't know. They may do more with it. Certainly, if all they have is a slide, all they can do is look at it. But on occasions, they have called back and said, "Send me the paraffin block," or "Do you have any wet tissue?" Or, "Do you have anything that we could put -- you know, do electron microscopy on," or something like that. From time to time, they would request additional material, which we would send if available.

Q. Okay.

A. Or sometimes, they have the capacity of doing a battery of special stains and interpreting it; for example, with lymph node, lymphomas. Cytomotry Associates would be the consultant, and we'd send it to them because they have the capacity to do the full panel of special histochemical stains to make the diagnosis.

Q. Are there any additional staining -- I think you mentioned that -- that could have been -- could have been done or could be done with the pathology slides that are presently available?

A. All of this could be done. Whether it would yield anything remains to be seen. But it

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could be done.

Q. Is it destructive to the slides to do these tests?

A. You can't do it on the slide that you have. You'd have to do it on a recut from the paraffin block.

Q. Okay. Are you aware if there are any recuts of the paraffin block?

A. To my knowledge, there are none.

Q. Okay. So I -- that's what --

A. Except for the routine histology step cuts.

Q. Is it -- and that's what I'm asking. Based on what is available today, is there any other staining that can be done, anything other than viewing of the slides?

A. If you limit yourself to the slides in hand, that's all you can do, is view them.

Q. Okay.

A. You can't -- you would -- you would destroy the existing stain reaction if you decolorized it and tried to do one of these.

Q. That's -- and that's what I'm --

A. You can't do it on a -- you can do it on a slide, but it will render it -- it won't be

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like it used to be.

MR. STUHAN: Graham, let's make sure that we're clear, for the record, here. I think Dr. Martin has made it clear that there's nothing more than viewing that can be done with the slides that have already been prepared. I'm not sure that was your question. If your question was, if you had more material, if there was still a block from which you could cut additional slides, is there more you can do, that's different. And I don't know what you intended to ask, but I wanted to make sure the record was clear on that.

MR. ESDALE: No, I -- and I think we are clear.

A. Yeah.

Q. Based on what is presently available, in the form of whatever your understanding is available, is there anything else that can be done other than view the slides?

MR. STUHAN: Well, your question assumes -- excuse me one second, Doctor.

Your question assumes that Dr. Martin knows whether there's a block out there somewhere that he hasn't seen. And I guess I should put this in the form of an objection, because I'm not

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sure that Dr. Martin knows one way or the other whether there is additional tissue out there from which additional slides can be prepared which could be subjected to special staining or electron microscopy or something else.

MR. ESDALE: Okay.

Q. (Mr. Esdale Continued): And that's -- I thought you said a minute ago -- and I might have been mistaken -- that to your knowledge, there wasn't anything else available.

A. Oh, no, no.

Q. Okay. Do you have an understanding as to whether there is --

A. Let me tell you -- let me tell you what my understanding is, and then --

Q. Okay.

A. -- we'll -- and then we'll work -- and then we'll come from that. We know for a fact that there exist slides, several slides -- I think there are three, maybe four, that are step cuts of the original tissue. They are stained routinely, and that's the only histologic material presently available that I'm aware of.

There must exist a paraffin block from which these slides were cut. That paraffin block,

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in most laboratories, would be retained for ten years. So it must exist somewhere. The paraffin block of the remainder of that biopsy tissue that has never been cut yet is sitting somewhere.

But to my knowledge, no special -- no sections for special staining were obtained. And the only other material available would be the couple or three cytology smears, and there would be no additional material from that. What you see is what you get on a cytology smear. There's no -- there's no cell block that I'm aware of.

Q. Okay. Assuming there is no paraffin block available, then we're limited to the slides?

A. Yes.

Q. Okay.

A. And if there is a paraffin block and you do nothing else, you're limited to the slides.

Q. Okay. Have you, at any time between November the 17th and yesterday, had any meetings or conversations with anyone regarding this case?

A. Telephone conversations with Mr. Duncan to arrive at a time to have this deposition and a request for the medical record, that I could review it to look for what I would look for in the medical record.

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Q. Was that just recently?
A. In the last -- well, whenever we -- this month -- in January.
Q. Okay.
A. It would have been in January, as we were trying to set up the times for depositions.
Q. Had you --
A. The medical record didn't come until Friday, though.
Q. Okay. So --
A. That's the first time I've seen the medical record.
Q. All right. What portions, if any, of the medical record were significant to you?
A. From my standpoint, the significant part is what was -- what was the initial history and physical on the gentleman when he presented to the doctor for treatment. And secondly, what was done following the initial history and physical. This, I believe, was Whitfield Hospital in --
Q. Demopolis?
A. -- Demopolis. In Demopolis. The next thing was, what was the findings of the pulmonologist, because the pulmonologist is the only one that had a firsthand look at the lesion

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intact.

So what is the gross observation of the pulmonologist? Which is the same observation that I would do if the lung had been taken out and brought to me, I would open the bronchus and look at it to see what the lesion -- to get a gross image of what the lesion looked like. So you look at -- you -- I wanted to know what it looked like to the -- to the person obtaining the biopsy.

The next thing was what actually was told to Dr. Datnow and what information did he have on which to base a diagnosis. And so I got -- I looked at a copy of his report and a copy of the cytology report just to see what he had said. And -- which is the same thing I would do if such a patient had been sent to Rush Hospital for management. I would have hoped that the treating oncologist would have wanted us to look at the slides, and in doing so, look at the permanent medical record as it pertains to the case in hand.

And then I scanned through the rest of it. I was looking to see what has happened over the years. And so I found a subsequent admission to Druid City Hospital where the -- where

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Mr. Acton had been seen sometime in 1997. And there was some reference to some rib lesions that were presumed to be recurrences, but -- and I think he was treated for that -- and yet there was no tissue diagnosis of -- no material removed, just an X-ray finding and management.

And that was the most of what I -- and I looked -- I looked at the -- when he was referred from Whitfield Hospital to Druid City back in -- was it '94 or '95? Whenever the original --

Q. Initial diagnosis was made?

A. Initial diagnosis. Was that -- it was '95, April of '95. He went there in May of '95 for treatment. I looked to see what subsequent workup they did at Druid City and discovered that nobody looked at the slides a second time. They did lots of other things, but they did not look at the pathology slides a second time.

Q. When you say "they," who are you referring to, specifically?

A. Pathologist, nobody. Nobody.

Q. All right. In other words --

A. There's no record that the -- that the pathologic material was reviewed, which is

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something I would have been looking for.

Q. Do you recall anything off the history and physical that was significant to you?

A. Well, it's all significant. But specifically --

Q. Well --

A. Give me a "for instance."

Q. Is this anything that stands out about the history and physical that is forming the basis of your opinions, unless the whole thing is?

A. The history and physical points to a tracheobronchial pulmonary process. So we know we're focusing on something that's going on in the lung because he presented with cough, and he presented with some hemoptysis, and so you've got that.

It was of interest to note that in the -- and there was no -- I don't think there were any significant other findings, other than this presentation. And then he had X rays that demonstrated a right hilar mass, or pulmonary mass, which was thought to be pneumonia, and he was treated for pneumonia.

And this is the usual and customary way of managing something like that. You presume

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you've got a patient with pneumonia, so you treat it. And when it doesn't resolve, then he comes back for further evaluation, and that's when he presented for biopsy.

It was of interest to note -- in lung cancer -- quote, lung cancer cases, end quote, you always look to see what social history they got from him. And it was of interest to note that the gentleman was a nonsmoker.

Q. What is significant about that?

A. He just didn't smoke. I mean, it would be recorded, in many instances, that a patient may or may not have had a history of smoking. This gentleman just simply didn't have a history of smoking.

Q. Is that something you would expect to see in lung cancer cases?

A. Smoking history -- I mean, when smoking history is obtained, many instances, for whatever disease is being -- might be evaluated or whatever, set of symptoms are being evaluated, it's not uncommon for the individual to have had some history of smoking. A lot of people smoke.

Q. So are you just commenting on the fact that there was no smoking history or history of

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nonsmoking?

A. No, I'm commenting on the fact that a big point was made that the man did not smoke.

Q. Okay.

A. In fact, in one instance, somebody rerecorded the history -- the past history later on in the course of this man's illness, and they made the comment that the man had a smoking history. And then they had to generate an addendum page to correct that error, and specifically, correct the record to say that the man did not smoke. But the people generating the record were making a big point of it.

Q. Okay. What is your recollection of the appearance of the lesion as the pulmonologist viewed it?

A. He -- his description was by way of calling it something.

Q. A viral papilloma?

A. He called it a viral papilloma, which connotes the appearance of a papillary lesion, namely fingerlike projections that look like a wart, a warty type growth projecting into the lumen. Which, if it were a viral papilloma, you would think in terms of the lesion that the human

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papilloma virus, HPV virus, produces. And that's a squamous lesion, whether it be produced in the nasopharynges, tracheobronchial tree, cervix, vagina, wherever the human papilloma virus produces a papilloma. This is what he was referring to. At least that's what you would think he was referring to if he said a "virus papilloma."

Q. Are there any other descriptions of significance in his description?

A. There's none in the record. He -- in his description, down in the context of his -- of his recording his procedure, that's what he said, that he saw something. I'm not remembering what he said in his opinion, which is up at the top of the page. I'd have to look at it again. Have you've got the --

Q. I think I do.

A. -- pulmonologist report there?

Q Is that what you're referring to, pulmonologist report?

A. Yeah, I think so. I was looking down in the bo- -- in other words, description of his procedure tells me what he was looking at, because there he was saying -- and he says, "everything

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looked --" this is just part of it -- "We went down the right side first and everything looked normal except the right posterior anterior lobule had a viral papillomatous looking lesion almost completely occluding it." I'm presuming he means the bronchus. "We biopsied this times 2 and did a brush biopsy. The rest of the bronchoscopy, which included the left side, was normal."

But then in his preoperative diagnosis, he said, "Unexplained lesion of right lower posterior lung field." That's just referring to the X ray. The postoperative diagnosis is a narrative, "Lesion in the bronchial tube which looks like a viral papilloma." Well, he's still trying to -- he's using a diagnosis to describe a lesion that he saw.

"The lesion measures three to four millimeters, and although I have seen cancer look like this, it is mighty small, and I am pretty sure we will be able to get it all out if there is --" "if, indeed, it is a mitosis." That's just his word for malignancy.

"We sent biopsies off. Will treat accordingly." But, I mean, he saw something that looked like a papilloma.

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Q. Right. And I just wanted to make --
A. Like a wart.
Q. I understand. And then I wanted to make sure -- is there anything else in his description that is significant to you, as a pathologist trying to diagnose a tumor out of his description, other than the fact that it looked like a papilloma?
A. It's -- well, it looks like a papilloma, it's in the bronchial, it's almost occluding the bronchus. It's not -- there's something growing into the -- into the lumen of the -- of the bronchial tree, rather than something that's squeezing it down.
Q. Okay. And is that, based on your training and experience, something that is uncommon for a small cell carcinoma?
A. Yes, sir, that be very uncommon for a small cell undifferentiated carcinoma.
MR. ESDALE: Go ahead and let's get this marked.
(EXHIBIT NO. 4 WAS MARKED FOR THE RECORD.)
Q. (Mr. Esdale Continued): At anytime --
A. That -- go ahead. I'm sorry.
Q. At anytime regarding this case, have

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you consulted with any other experts or doctors or laboratory personnel?

A. No, sir.

Q. Have you consulted with anyone other than Mr. Duncan and Mr. Ingram or Mr. Stuhan or Mr. Bassett?

A. No, sir.

Q. Have you reviewed any deposition testimony?

A. No, sir.

Q. Do you plan on doing any other work in this case?

A. Such as?

Q. Well, anything. In other words, do you -- is there any other materials that you have asked to review or would like to review before trial?

A. My understanding is that there's nothing available to review.

Q. In the way of pathology?

A. Yeah. I mean, I don't -- yeah, from its -- from a standpoint of pathologist. I don't know what other people would think would have any bearing on what I think, but --

Q. That's fine. I just --

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A. To the extent that, you know, that I can interpret. But if there's -- you know, if there are other folks with other information, that would be useful at their level. But at my level right now, this is -- I don't know of anything else that I need at the moment. There may be literature that I become aware of that I'm not aware of at the moment that I would want to look at, but that's all.

Q. How much time have you spent on this case to date?

A. About six hours, give or take.

Q. How do you charge?

A. Two hundred and fifty dollars an hour.

Q. Is that for all time, reviewing deposition, trial, everything?

A. Time spent.

Q. Okay. I think you said you do have access to a case list of other cases that you have?

A. Yeah, I have -- I have a record of all the medical legal and other litigation cases that I have been consultant to over the past ten years, most of which are malpractice cases and not tobacco litigation cases.

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Q. Okay. Do you have any idea about the percentage of time you would spend testifying or consulting on behalf of the plaintiff versus the defendant in a medical malpractice case?

A. I don't have any -- I have not been consulted by a plaintiff's attorney.

Q. So all your testimony has been defending medical malpractice cases?

A. No. Well, I mean, you -- I don't defend them. I just simply consult on them.

Q. Okay. For the defense?

A. Yeah. The attorneys -- yeah, they -- my consultations have been -- have been requested by defense counsel.

Q. Okay.

A. Put it that way.

Q. Is that also true for the smoking and health cases?

A. Yes, sir.

Q. Have you ever testified at deposition or trial in a smoking and health case?

A. Yes, sir.

Q. On how many occasions?

A. Testified at trial in two. Testified at deposition in -- one, two, three -- I believe

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this is the fifth one.

Q. All right. Just so I'm clear, did you also give deposition testimony in the two cases that you testified at trial in?

A. Yes, sir.

Q. Now -- and then have you given depos in three other cases in addition to that or five other cases in addition to that?

A. Three.

Q. Okay.

A. Including this one.

Q. All right.

A. That's just my memory. It's on that -- it will be on that piece of paper.

Q. All right.

A. But that's the best of my memory at the moment.

Q. Does that piece of paper contain what opinions you expressed at the trials or depositions?

A. No, sir.

Q. Can you tell me what opinions you did express at those -- let's start with the trials first.

A. Which trials?

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Q. The two trials that you testified in.

A. The first was Horton versus American Tobacco Company. That was -- gracious, 1991, somewhere along -- '90, I believe.

Q. Okay.

A. And the substance to which I testified was that the gentleman suffered from a large cell undifferentiated carcinoma giant cell variant and a peripheral carcinoma of the lung. And that was the substance of my testimony in that case.

Q. Do you recall what the plaintiffs were contending in that case?

A. That his cigarette smoking caused his lung cancer.

Q. Did that case involve the issue of a differential diagnosis?

A. I think only to the extent that we -- I maintained that it was a large -- that it was a giant cell variant of a large cell carcinoma. I think the large cell carcinoma was not in contention. I don't really recall, but I don't believe it was a contention of diagnosis.

Q. Do you know how your testimony was relevant to that case, as far as issues of causation, or did you express any opinions

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regarding causation?

A. That -- to the extent that no clear-cut causation has ever been defined for large cell undifferentiated carcinoma of the lung, giant cell variant or otherwise. It's just never been established.

Q. All right. The other trial case, you recall that?

A. The other one was Covert versus Laurel Lott, et al. -- or Philip Mor- -- or somebody. And it was in Baton Rouge. And this lady had a peripheral adenocarcinoma. And that -- the diagnosis was not in dispute. Everybody agreed that she had an adenocarcinoma. We did establish the -- I did establish the fact that the record identified it as a peripheral carcinoma versus a central carcinoma and that adenocarcinomas have not been clearly associated with smoking as a potential etiology.

Q. Are you speaking of peripherals or adenos -- all adenos?

A. Adenocarcinoma of the lung. Does not -- does not -- no one has ever demonstrated a clear-cut etiology or a strong statistical relationship between adenocarcinomas of the lung

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and any specific etiologic agent. There are a lot of the things suggested, but no clear-cut etiology for adenocarcinomas of the lung, most of which are peripheral.

Q. Okay. The Horton versus American Tobacco --

A. Yeah.

Q. Where was that case?

A. Oxford. That's the second trial. First trial was in Lexington, Mississippi, but I didn't participate in that. I participated in the second trial, which was in Oxford in federal court. The covert trial was in federal court in Baton Rouge.

Q. Okay. The other three depositions -- and I assume you gave depositions in both of those cases also?

A. Yes.

Q. And I assume your opinions in those depositions were the same as it was at trial?

A. Yes, sir.

Q. All right. Let's briefly discuss the other three cases you gave depositions in.

A. One of them is Gilboy, which is another peripheral adenocarcinoma of the lung by

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the same plaintiff's attorney in Baton Rouge, Mr. Covert. The first one happened to be his wife -- his ex-wife, Covert versus -- etcetera. Gilboy is another peripheral adenocarcinoma that has not come to trial, has -- the deposition was, I guess, more than five years ago. A long time ago. Four or five years, something like that. And it's another peripheral adenocarcinoma, and just the same, has not been tried as of this point in time.

Q. Were your opinions related to a differential diagnosis, or was it just that --

A. No, he had a -- the diagnosis of record, as I recall, is adenocarcinoma.

Q. All right. And was your testimony similar in that -- as of the time you gave that deposition, or I assume even today, that there's no strong association between adenocarcinoma of the lung and cigarette smoking?

A. None has been demonstrated, that's correct.

Q. All right. Other deposition?

A. Well, one of them is this one.

Q. Okay.

A. So we just --

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Q. Down to one left other than this one.

A. One left. The other one is Carney versus Philip Morris, which is presently, as I understand, in trial in Memphis.

Q. Okay.

A. I mean, I really don't know. It was supposed to go to trial in January, and I've not heard anything further from defense counsel since then. But the deposition was concerned with Carney. This is one of five or six separate cases that are merged into one trial.

Q. Sure.

A. In this instance, Mr. Carney has a peripheral adenocarcinoma of the lung, and that's not in dispute, as I recall. The interesting part of that gentleman is that he is an over -- was an over-the-road truck driver, and there is some literature to indicate that there is a relationship between chronic exposure to diesel exhaust and the development of adenocarcinomas of the lung.

And there is laboratory evidence that the residues or extracts of diesel combustion products can cause the development of adenocarcinomas in laboratory animals, which is

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significant, and that most such attempts to develop a laboratory -- tumors in laboratory animals have been -- have failed.

The other thing that's interesting about this case is the man has a mass lesion of the kidney that was never further identified, and the histologic features of the tumor in the lung could be consistent with a metastatic carcinoma of the kidney.

Q. Have you, in this case, assuming this is small cell carcinoma --

A. Which case would that be?

Q. Acton. In Acton, assuming this is a small cell carcinoma, have you seen anything in any of the medical records or otherwise that would indicate that this tumor did not originate in the lung?

A. This -- the assumption is yours, not mine.

Q. Right. I understand that.

A. This is small cell undifferentiated. And nothing that I have discovered in the medical record, nor that has been brought to my attention otherwise, has indicated that there is a primary tumor someplace else. So that the lesion,

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whatever this is, appears to be a primary lesion of the lung.

Q. Okay. Earlier you had mentioned and discussed regarding the peripheral adenocarcinomas of the lung, that there was no statistical or strong statistical association. Do you differentiate between a strong statistical association or just a statistical association? And if so, how?

A. I -- I'm -- it's -- I don't -- I don't try to split the hairs on that. I'm just simply taking the sum total of my knowledge of what's recorded in the literature by various authors. And all of them, to a person, said that they've never been able to clearly identify the etiology of adenocarcinomas of the lung, although some of been -- some do, in fact, occur in people that smoke.

Most of them occur in females. But the fact that you find an adenocarcinoma of the lung in a male doesn't mean anything bad. It's just that it can occur in males, too. And it can occur in smokers and nonsmokers. But nobody has ever identified a clear-cut etiology for the class of adenocarcinomas of the lung.

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Q. Has anyone ever identified a clear-cut etiology for small cell carcinoma of the lung?

A. There have been lots of studies that have epidemiological and statistical studies that shown strong statistical relationships between a history of smoking and the diagnosis of a small cell undifferentiated carcinoma. But again, they are statistical associations.

Q. I understand that. I assume that your testimony -- or let me just ask it this way: Have you ever seen a case of lung cancer, of whatever form, that were caused by smoking?

A. I don't -- I'm not convinced that the -- that anyone has produced a carcinoma of the lung with cigarette smoke. All of it is statistical inferences.

Q. Do you know any of the other experts, whether for the plaintiff or defendant, that have been named in this case?

A. (Witness shakes head negatively.)

Q. You my not know who all have been named, and I didn't -- I don't think I brought that list with me.

A. I know there's -- I know there's some others, but I don't know them. I don't know who

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they are.

Q. Are you familiar with Dr. Gould, who's a pathologist in Chicago?

A. Not by name.

Q. You don't recall ever meeting him or working with him on any cases?

A. I don't know him.

Q. Okay. What about a Dr. Spivak? Rick might be critical of my pronunciation of that. I still can't say it like he does.

A. I don't -- I don't -- I really don't know any of the others that might be in -- I don't know anybody involved in this case.

Q. Okay.

A. Except, you know, defense counsel.

Q. Right. No other experts?

A. Huh-um (negative response).

Q. What about any of the doctors that were involved in the treatment of Jimmy Acton, as far as what you may have seen in the records?

A. Not that I'm aware of.

Q. You don't know Dr. Borris Datnow?

A. No.

Q. Not familiar with him in any way?

A. No, sir.

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Q. Or Dr. Perret that did the bronchoscopy?
A. No, sir.
Q. Drs. Hinton, Young, or Graham?
A. Not that I'm aware of.
Q. Dr. Shelby Sanford?
A. Not that I'm aware of.
Q. Do you know Dr. David Thrasher?
A. No, sir.
Q. Pulmonologist in Montgomery?
A. No, sir. They would not have -- we wouldn't have contact that direction.
Q. Well, I just didn't know, because --
A. I mean, we don't. That's why -- when you mentioned the names, I searched -- I searched my memory, but I don't -- I don't know that I'm -- I know them.
Q. Okay. Do you practice medicine in Alabama, or are your licensed to practice in Alabama?
A. I have a -- I have a Alabama license, but I don't physically practice in Alabama.
Q. You don't review pathology slides furnished from locations like Livingston, Alabama, Demopolis or anything like that?

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A. If they come to me I would, but, I mean, I don't -- I don't need an Alabama license to do that, so long as I practice in Mississippi.

Q. Well, that's what --

A. They don't -- normally -- well, when we had a hos- -- when we owned the Hill Hospital up in York, we would get material from York from time to time. When we owned -- when Rush Health Systems owned the hospital in Butler, Alabama, we would get material from Butler from time to time. We get biopsy material and cytology material from Gilbertown, from a clinic down there, and from a clinic in Butler now.

Q. Do you know who owns those clinics?

A. Rush Hospital -- Rush Health Systems.

Q. Do you work for Rush Health Systems?

A. I work for Rush Medical Group.

Q. Okay. What is that?

A. Rush Medical Group is a multispeciality group of doctors of about 50, give or take, in multiple different medical specialties.

Q. Do y'all own -- the group of doctors own the corporation, or is that what it is?

A. It's a professional association.

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Q. And I -- and then I assume you have an ownership interest in it.

A. A stock interest, just like any other of the full members would have.

Q. And do you only perform, to your knowledge, pathological diagnoses that are received from Rush Hospital facilities?

A. I'm not aware that -- no. No, we get -- we get pap smears and biopsies from freestanding clinics here in the city that are not part of Rush Health Systems.

Q. Nothing from Alabama, though, to your knowledge?

A. Not that I'm -- well, the patholo- -- cytology and biopsies from the Gilbertown clinic, but that's a -- that's a Rush Health Systems --

Q. Right. Other than Rush Health Systems, to your knowledge, nothing from Alabama?

A. No. I've seen material from Whitfield Hospital before, but I don't remember the context. It was a -- I mean, it was a clinical context, but I just don't remember specifically what it was.

Q. Do you or -- other than your relationship as a consultant to the various

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tobacco companies, do you know any employees for -- of the tobacco companies or the law firms on any type basis other than professional?

A. No.

MR. STUHAN: I'm going to object to that question. I don't believe the doctor has testified that he served as a consultant to tobacco companies. He said he's consulted with various law firms and lawyers to have represented tobacco companies. But he hasn't said anything about being a consultant for tobacco companies.

MR. ESDALE: Okay.

Q. (Mr. Esdale Continued): I didn't mean to mischaracterize your testimony.

A. No, I'm not -- I'm not a -- I'm not a consultant to anybody except on a case-by-case basis. If they ask me to look at it, I'll look at it. But I'm not a -- I'm not a consultant to Philip Morris or Laurel Lott or --

Q. Sure.

A. -- American Tobacco.

Q. It was a poor question. I didn't mean to mischaracterize --

A. That's okay.

Q. -- your -- situate your status with

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them. What I'm trying to get at is, do you have any -- do you know anybody that works for any of the tobacco companies?

A. Well, I met the vice-president in charge of research one time for American Tobacco Company by way of the Horton trial, but, I mean, that would -- not really have a personal acquaintances with employees of any tobacco companies, no.

Q. Okay. What about any of the attorneys that represent any of the tobacco companies?

A. Do I have any personal relationship with them?

Q. Right. I mean, did you -- right.

A. No. I mean, I don't know them other than in the context of consulting on a particular case.

Q. Okay. Have you been asked to -- or -- well, let me ask it this way: Does your facility, your laboratory, have the capabilities of making photomicrographs?

A. Not very well, no.

Q. Okay.

A. I tried it one time, but the equipment's not -- I can't use it.

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Q. All right. Did you ever -- have you ever had photomicrographs made in the past?

A. There were photomicrographs enlargements of -- for trial in the Horton case. I don't believe that there were any made for the Covert case. None have been made for any of the other tobacco cases. And I can't remember any photomicrographs for medical litigation cases.

Q. Did you assist or make the ones in the Horton case?

A. I identified the areas to be photographed.

Q. Do you know who did the photomicrographs in that case?

A. Somebody in New York. I just -- I just circled areas on the slide, and I said take a picture of that. And then I just -- somebody took a picture. And then I physically related the image of the photograph back to the microscopic slide to confirm that it came from the microscopic slide.

Q. All right. If you would -- I think that's Exhibit 2. Take a look at that, and we can kind of go through it together.

A. All right.

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Q. Did you help prepare this document?

A. No. This was -- this was prepared by counsel based on the substance of what I discussed mostly at the time of this first meeting.

Q. And I assume -- I think you said earlier you've had a chance to review that document?

A. Yes.

Q. And is it correct in all aspects that --

A. Substantially so.

Q. Okay. If you would, let's start with -- and I know your CV is on here, but --

A. Yeah.

Q. It might save me just a little bit of time. Are you board certified in anything other than pathology?

A. Pathology is my certification.

Q. If you would go to the second paragraph.

A. Yes, sir.

Q. It says that Dr. Martin will be offered as an expert in the fields of pathology and medicine as they relate to the role of a pathologist in the diagnosis of benign and

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malignant tumors.

A. Yes, sir.

Q. What is the role of a pathologist in the diagnosis of malignant and benign tumors?

A. The same as it is in the diagnosis of any other lesion that has a tissue presentation; and that is, the pathologist is the one who establishes the diagnosis, if can be established. So the material is removed, biopsied, excised, whatever, and presented to the pathologist to determine what the nature of the pathologic process is; namely, what is the diagnosis.

Q. Is that something you do as a part of your business on a daily basis?

A. For 33 years, yes.

Q. Could you briefly describe the process that you use in your day-to-day operations, how you receive the biopsied material, or specimens, and what you do with it? Just, again --

A. The -- depending on the nature of the case determines what you receive, of course. But it may come to me as a fresh biopsy, it may come to me as an intact organ, it may come to me already previously partially fixed in formaldehyde. But it comes to me not having been

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otherwise manipulated except by removal from the individual, by the surgeon or whomever performed the biopsy. In this instance, it would have been the pulmonologist.

And you look at it, and you describe what does it look like grossly, you know, what I -- what I -- what, physically, does it look like. In the case of an intact organ, you would be describing the anatomic features of what, in this instance, would have been, say, a lung. You would describe the various components of that organ.

In the case of a small, itty-bitty biopsy such as this, it's just a small, itty-bitty piece of tissue of such-and-such size and color and consistency. If it's a small specimen, you put the whole piece through for fixation and processing, and subsequently, it gets embedded -- infiltrated and embedded in paraffin, of which permits you to obtain your histologic slides the following day.

In the case of an organ removed, you would look at it to determine where are the abnormalities in this organ. You, of course, are interested in what doesn't look bad, but what

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you're mostly interested in is what's not normal, because what's not normal determines where you take your pieces of tissue for histologic study. And you take sufficient pieces of tissue from the abnormal areas that would permit you to give an evaluation of the nature of the lesion, entirely, without having to submit the whole thing. You can't submit the whole thing, so you take representative pieces of it.

Sometimes you need more than just the diagnosis. Sometimes you're interested to know has the lesion -- if it's a tumor, has -- and it's malignant, has it spread to the contiguous lymph nodes, whether it be a breast specimen or a colon specimen or a lung specimen, you would want to know. You've got something in the lung, is it now someplace else as well for staging purposes?

The other thing are your margins of resection clear? Is the lesion sitting in the cut line, or is it remote from the cut line? If so, how far remote from the cut line? Because if you're trying to surgically remove a malignant lesion, you would like to know that you got around it, rather than cut across it. So you'd be looking for margins of removal.

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And then whatever else the tissue presents to you, because it will -- many times, the tissue will -- well, reveal to you what you need to do with it. In the case of a -- of a lymph node, for example, if it's sent up -- sent fresh for diagnosis, if the suspicion is that of a lymphoma, then you want to do more than just simply take bits and pieces for histologic study, routine histologic study. You would also want to take some and put in transport medium and send off to reference laboratory for specialized studies, such that, if it does -- if you do determine that it's a lymphoma, you want to know what type, because that will define what the treatment will be. And you can't always tell the type from just looking at the histologic slide.

Other instances, it might be appropriate to send material for electron microscopy, which you would obtain fresh, put in a different fixative, and send to a different laboratory for evaluation.

So it depends on what you're looking at as to what you do with it.

Q. Once you get it in, does your lab prepare it for slide presentation?

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A. The pathologist or one of the technicians -- if it's -- if it's small biopsies, the technicians oftentimes handle the small biopsies, because there's not much do with it except pick it up and move it to the next stage and process it to paraffin.

But we prepare the tissue to be examined. This then goes into a machine for dehydration and processing. And the next morning, it's infiltrated with paraffin, ready to go. Still liquid paraffin, but --

Q. Fairly automated process?

A. That's an automated process. The tissue is all identified in little tissue carriers by case number and block number so that we can bring the case back to the same report. And the technicians will then take it out of the liquid paraffin and put it into -- and mount it in paraffin so that it will be, you know, solid, and then just put it in the freezer, and it solidifies.

So now you have your tissue firm enough to put in your microtome so you can cut thin slices, put them on a slide, remove the paraffin, stain it, put a cover slip on it, and

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the pathologist looks at it.

Q. Now --

A. All of that is done in house.

Q. Right. How -- once the slides are cut -- or the paraffin block is cut and the material's placed on a slide for your review, how do you receive those? Are they in a tray?

A. Sequentially in a tray.

Q. All right. And do you have your --

A. With all of the other cases of the day.

Q. Is there paperwork accompanying the slides, or is it on a computer, or how does that work?

A. At the time the tissue is examined, I dictate what I see. I dictate what I do with it. And that, then, is transcribed, and the next morning it's available to me at the time I'm looking at the slides so that I am reminded what it was that I saw yesterday to go over the slides that I'm looking at today.

Q. Do you do this by yourself?

A. You mean examine --

Q. Examine the slides.

A. Yeah. Oh, yeah.

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Q. And then you don't have the doctors come in and look at the slides with you?

A. Not until I'm through. They may, you know -- I don't need them when I'm making my diagnosis, no.

Q. Do you, as a regular basis, have the doctors come in and examine the slides with you after you've made your diagnosis?

A. No, sir.

Q. Is that something unusual?

A. It's not -- you said "regular basis." It's not on a regular basis. It's on a -- it's -- it depends on the level of interest of the doctor. The oncologist will come up to look at his bone marrow smears or his lymph node biopsies because he's interested to see what it looks like.

One of the gastroenterologists may come up from time to time to look at one of his colon biopsies. Or the pulmonologist may come over from time to time to look at a lung biopsy. But generally, regularly, no.

Q. Okay.

A. I would say 95 plus percent of the cases are signed out without the clinician coming

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to specifically look at the slide.

Q. Okay.

A. Now, I may pick up the phone and call them and ask them something about it, but not to regularly look at the slide with me.

Q. Okay. Do you have any criticisms or plan on offering any opinions regarding the handling of the pathology or the specimen in this case?

A. I don't know anything that would raise any suspicion about how it was handled.

Q. You haven't --

A. I don't know anything -- I don't know anything except that it was removed by a pulmonologist in Demopolis and sent, somehow, to Dr. Datnow in Birmingham. And I would have to presume that it went to him in form, but I don't have any facts.

Q. Did you look at his pathology record?

A. Yeah. I just don't remember what he said.

Q. If it said it was --

A. How he -- how he received --

Q. -- it had 10 percent -- I'm sorry, I didn't mean to interrupt you.

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A. No, I said I just do not recall if he specified -- he may -- he may have said it was received in form. I just -- I presume that on an automatic basis, you wouldn't send it across state unfixed.

Q. Sure. And I -- and I understand that. I just want to make sure you haven't seen or don't plan on offering any opinions regarding

A. I don't -- I don't know that it was not handled appropriately.

Q. Okay.

A. I don't have any knowledge.

Q. And you don't plan on testifying to that?

A. That it was handled inappropriately?

Q. Right.

A. No.

Q. The next sentence in paragraph two says, "Dr. Martin will also offer his expert opinions on the diagnosis in the medical records of Mr. Acton's tumor." What opinions do you plan on offering regarding the diagnosis in the medical records?

A. I don't think that the diagnosis of

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undifferentiated small cell carcinoma is substantiated in the material.

Q. All right. And I just want to make sure we're clear on that. Are you basing your opinions on your experience as a pathologist, looking at the slide and saying that the medical records are wrong on that, or are you using the medical records -- something in the medical records to base your opinion on?

A. I looked at the slide and I based the opinion on what I saw in the slide, based on my totality of experience as a pathologist, looking at similar material. And the cases that, in my experience, have been diagnosed as undifferentiated small cell carcinoma don't look anything like what this slide looks like.

Q. It says, "Dr. Martin may also be called upon to comment on matters raised in the testimony of other witnesses as they relate to his area of expertise." And at this point in time, do you have any idea about what other witnesses have testified to?

A. No, but I would presume that if Dr. Datnow were a witness, that he would testify to something that caused him to make the diagnosis

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that he made. And I may be asked -- since he would be a plaintiff's witness, I would be asked after the fact to comment on whatever Dr. Datnow may or may not have said. But I can't presume what he would say. But he's got something in his mind that caused him to call this a small cell undifferentiated carcinoma. I just don't know what it is.

Q. All right. "Dr. Martin will testify regarding --" again, third paragraph "-- the techniques, procedures, and criteria used by medical practitioners in pathology to diagnose disease, including cancer."

A. I -- we covered most of that.

MR. STUHAN: Excuse me, Doctor. Is there a question in there?

MR. ESDALE: Yes.

Q. (Mr. Esdale Continued): What are you going to testify about regarding the techniques, procedures, and criteria used by medical practitioners in pathology to diagnose disease, including cancer?

MR. STUHAN: Well, I object to that. I think that Dr. Martin has just testified to that very subject at great length. And the question is

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redundant.

A. My only answer would have been that we had just -- I had just recited that. The fact that it's cancer or not cancer is determined at the end of the procedure. All the procedures up until that point in time are usual and customary. And then you put it in the microscope, and your diagnosis is established if you can establish it at that point in time.

Q. So nothing other than --

A. So it doesn't make any difference whether it would, you know -- it would have been handled the same way if it were something other than cancer. It's just that -- it doesn't become cancer until you look at it and it fulfills the criteria of diagnosis.

Q. Okay. Is there anything additionally you're going to offer in the way of opinions regarding techniques, procedures, or criteria, other than what we've just discussed, as far as your preparation and handling of the specimens, things of that nature?

A. Not that I'm aware of.

Q. Next sentence says that you will testify that lung cancer is not one disease, and

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the term "lung cancer" is sometimes used to describe any one of several kinds of malignant tumors. What testimony do you plan on offering regarding the different types of tumors?

A. That depends on the question answered, but -- because the -- there are lots of answers depending on the questions. But in generality, lung cancer is not a homogenous disease. It has lots of differences, not the least of which it is the histologic type. And it's accepted that it's appropriate to define the histologic type of lung cancer. So for whatever reason, it's of importance that the various forms of lung cancer be distinguished, one from the other. That's number one.

Number two, it has -- it is of some interest to many, but not to all, as to whether the cancer originating in the lung is occurring in a central location; i.e., bronchial tree, or is it occurring in a peripheral location; i.e., pulmonary parenchyma, and that some observers feel that the location of origin of the tumor has a bearing on what its presumed etiology might be.

The literature saying that those tumors that originate in central locations tend to

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have a stronger statistical association relationship with quasi, cause, and effect between cigarette smoking and the occurrence of tumor, whereas those tumors that originate in peripheral areas of the lung do not have such strong associations implied. It's certainly a variety of lesions.

And then there are another group of tumors that are very uncommon, that have no relationship to anything except that they can occur in the tracheal bronchial tree as easily as they can occur in salivary glands or in other locations, and that would be the carcinoids or the neuroendocrine tumors, which can occur in the gastrointestinal tract, the adenomas, bronchial adenomas that are perfectly benign, but can occur in the bronchial tree and occlude the bronchus, and a whole -- you know, a whole variety of things.

It's just not a -- it's -- again, depends on the question asked, but there's a lot of dissimilar -- the only thing similar between the various lung cancers and one another is that fact that they're in the lung, physically present in the lung.

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Q. Do you use a system to classify tumors?

A. Yes, sir.

Q. And how --

A. It's a -- it's a system that's accepted by most people concerned with lung cancers, and that's the classification of World Health Organization that divides it into four general histologic classifications.

Q. What is -- and just for my benefit, when you say "histologic" --

A. The four general classifications are squamous cell carcinoma --

Q. Let me stop you just for a second. I'm not trying to interrupt you. What do you mean by the term 'histologic," first?

A. Histologic --

Q. Origin?

A. Tissue. No, tissue appearance.

Q. Okay. And then based on that --

A. Yeah, the histologic -- the histologic features, by definition, is what does it look like when you put it on the stage of a light microscope and look at it. In other words, a histologic slide defines the histologic characteris- -- the

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appearance of the tissue, what is the tissue appearance of the tumor. So the four classifications are squamous cell carcinoma, small cell undifferentiated carcinoma, adenocarcinoma, and large cell undifferentiated carcinoma. Those are the four general classifications.

Q. And in this case, in the Acton case, I assume that it is your opinion that Mr. Acton's tumor is not any of those.

A. That's right.

Q. Now, do you have an opinion as to whether his tumor is central or peripheral?

A. I know it's central, because it's in a major bronchus. By definition, anatomically, it's central.

Q. Okay.

A. Even if nobody calls it central, that's what it is, it's central.

Q. Now, let's go on with the next sentence. You might have already covered some of this. "It is Dr. Martin's opinion that Mr. Acton's lung tumor exhibits neuroendocrine characteristics."

A. Yes, sir.

Q. An is that what you were talking about

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a minute ago when you started --

A. That.

Q. -- talking about other tumors?

A. That comment was one of the flight of ideas that was going through my head at the time I looked at the slide, and it was just one of several things that popped out of my mouth.

Namely, if it's not small cell undifferentiated carcinoma, and it's sitting as an exophytic lesion in the bronchus, what might it be, if it looked this bad on this histologic slide, recognizing that the -- to me, the cell of content, the lesion of cells of this biopsy are so necrotic that you're dealing with conjecture trying to figure out what it is, just based on that slide.

It does not have the background or general characteristics of a small cell undifferentiated carcinoma, it doesn't show me any squamous differentiation whatever. It doesn't have any clear-cut adeno features that are preserved, and they're not large cells, so that eliminates large cell undifferentiated carcinoma.

What could look like this in a necrotic state? That's what I'm trying -- was

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trying -- and that's where that comment came from. It might be the necrotic end product of a neuroendocrine tumor, which can occur in the bronchus, namely a carcinoid, a carcinoid perfectly benign lesion that could occur that might have a sort of nesting pattern of necrotic cells left behind is -- because that's what we're looking at, is a necrotic lesion, trying to figure out what might it have looked like before it became necrotic. And neuroendocrine tumor would be a possibility.

Q. Do you have any opinions on how it became necrotic?

A. Yeah. We know for a fact that Mr. Acton had a pneumonia that was distal to this obstructing lesion that was caused by Serratia, S-e-r-r-a-t-i-a, marcesans, m-a-r-c-e-s-a-n-s, marcesans. And this microorganism produces a necrotizing bronchial advertising pneumonia, which means it will -- it will necrose; the tissues, it will destroy the tissues as it produces the pneumonia that goes along with it.

Well, if it can do that to the lung, that's distal to the obstructing lesion might it have also invaded the lesion and produced

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necrotizing process here.

The lesion, to my -- to my evaluation, based on my experience, is necrotic something. Something caused it to be necrotic. We know that a necrotizing microorganism is part of this man's problem, and it's contiguous to lesion, so that might be a possibility.

The other possibility is that the -- since this was a papillary growth projecting into the lumen, it may have twisted and cut off its blood supply. And that would have produced -- it would have infarcted, which is just a term for generalized necrosis of the entire lesion.

Certainly, he didn't have any preexisting treatment that would have produced a necrosis. It's not a necrosis that would have been associated with the presumed pathology process of small cell undifferentiated carcinoma, because this is not the pattern of such necrosis.

So exactly what caused it, I don't know. But there are two possibilities for this lesion in this place in this person.

Q. You mentioned that this is not the pattern of necrosis in a small cell carcinoma?

A. That's right.

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Q. What is the pattern of necrosis in small cell carcinoma?

A. The diagnosis -- the diagnosis of a small cell undifferentiated carcinoma is based on a couple of features, part of which is the presence of necrosis. Necrosis, by itself, is not the pathopneumonic characteristic. It's just a tumor that -- it is a tumor that will have large irregular areas of necrosis scattered throughout it.

But the diagnosis of the tumor is based on the fact that it occurs in broad sheets of small cells that may have round hyperchromatic nuclei or have elongated tapered hyperchromatic nuclei, cells that will be of a size two to three times the size of a normal lymphocyte.

But the cells occur in sheets of tumor with irregular areas of necrotic tumor scattered here, there, and yon. But you would have sheets of viable tumor upon which you could make the diagnosis.

One of the other things that can occur with such a tumor is that it has a certain fragility in that it can be crushed. It's easily crushed as you try to take a biopsy.

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So in small cell undifferentiated carcinomas that you are -- diagnose, you're not -- you frequently will find areas of squashed tumor, and you frequently will find areas of -- broad areas of necrotic tumor.

But your diagnosis is based on the viable tumor that's neither squeezed nor dead. It's just that the crush artifact and the necrosis are just parts of a tumor that's diagnosed by its viable histologic features.

And there are no viable histologic features in this lesion that, to me, would suggest, in any way, a small cell undifferentiated carcinoma. There are just -- there are no sheets of tumor cells there.

Q. So you didn't -- you didn't see any sheets?

A. They're not there.

Q. Did you see any crush artifact?

A. Only at the -- at the bite mark, at one edge of the biopsy.

Q. Could you tell where -- was there just one edge of the bite mark?

A. I really don't -- didn't pay that much attention to it, because you don't learn much from

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the bite mark. You learn -- you study the rest of of. But it just -- if you -- if you got a papilloma lesion sitting there, and he tries to biopsy, he's going to try to put his clamp over it, the other side is going to get pinched as you take the biopsy. And it just happened to have an pinch mark on one side. Whether it had it more than one place, I just don't recall, because how many pinch marks is of no importance.

Q. Do you -- next sentence, last one in that paragraph, it says that you're of the opinion Mr. Acton's clinical course is inconsistent with the diagnosis of small cell lung cancer.

A. Yes, sir.

Q. And specifically, what in the clinical course --

A. Specifically is, on a very rare person with a bona fide diagnosis of small cell undifferentiated carcinoma would have lived five years. So it would be highly unusual for such a person with such a disease to be disease free five years later and alive.

Q. Does that happen occasionally?

A. Lots of things happen occasionally. I say it would be very unusual. Less than 10

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percent would have survived three years.

Q. Would you defer to treating physicians on survival rates, oncologists, for instance?

A. They might -- they might have more specific knowledge of precise numbers than I do. I just know in a general sense, patients with a diagnosis of small cell undifferentiated carcinoma have a very limited life expectancy.

Q. Do you have any ideas about what percent of lung tumors are carcinoids?

A. Rare.

Q. How rare?

A. I don't know.

Q. One percent?

A. I don't know. It's listed in the uncommon lung tumors.

Q. When you say "listed" --

A. No, no, where it's listed -- it's listed in the common lung tumors, but it's listed in the -- in the broad category of neuroendocrine tumors, which go all the way from a carcinoid to an undifferentiated small cell on the other end.

Q. What you say "listed," listed by whom?

A. In the textbooks. It's grouped. It's grouped in the textbooks as part of the common

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lung tumors because of the fact that it's described in the same general area that other neuroendocrine tumors, both large and small, are described, and in the same area, or same category, as the small cell undifferentiated carcinomas, which, from time to time, can demonstrate neuroendocrine features.

Q. What --

A. Now, but your question was how common is it. Carcinomas -- carcinoids are not common.

Q. The -- what textbooks are you referring to?

A. This would be Dale and Hannah's textbooks of pulmonary pathology or Therabecks textbook of pathology -- pulmonary pathology. Both of them are pulmonary pathology.

Q. Okay. Do you -- are there any texts that you find reliable and authoritative as they relate to pulmonary pathology?

A. There are -- there are many texts that are informative and are useful in trying to evaluate the pulmonary disorders. As to whether they're authoritative or not, it may be authoritative to the extent that they compile all the available knowledge that exists on a

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particular disease. But if you say they're authoritative because they're the final word on anything, medicine is always changing, and not all opinions are subsequently backed up by facts.

Q. Other than the fact that he's alive four years post diagnosis, is there anything else about the clinical course that leads you to -- that leads you to the opinion that his diagnosis is inconsistent with small cell carcinoma?

A. I'm not relying on the clinical course to render an opinion. My opinion is based on what does it look like in the microscope. And my comment was it would be unusual for a patient with small cell undifferentiated carcinoma to be alive this long.

But the opinion as to the fact that this is not a small cell undifferentiated carcinoma has nothing to do with how long he's lived.

Q. I assume, then, that is based on what you see in the microscope --

A. Yes, sir.

Q. -- when you look at this. If you will move on to the next paragraph, it says that based on the available material and the medical history

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and clinical course and your own experience and expertise, you would not draw conclusion as to the specific type of neuroendocrine tumor found in Mr. Acton's lung.

A. That's right.

Q. What are your reasons for not drawing a conclusion as to the specific type of tumor?

A. In my experience, it is, to me, improper to try to establish an unequivocal diagnosis based on necrotic material. You can conjecture what it might be, trying to, again, guess, looking at necrotic cells, what might they have looked like in a non-necrotic state before they -- before they became necrotic.

And the reference is to neuroendocrine lesions, is that it might have been a previous neuroendocrine lesion may have wound up looking like this in a necrotic state. But a bronchial adenoma has got nothing to do with neuroendocrine cells may have wound up looking like this in a necrotic state. A carcinoid, which is a well-differentiated part of the neuroendocrine, might have looked like this in a necrotic state.

But this is a necrotic state, and all you can do is guess what it might have been. But

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one thing for certain it's not: It's not a small cell undifferentiated carcinoma, because it does not have any of the histologic features, that I'm aware of, that established the diagnosis of small cell undifferentiated carcinoma. Now, guessing what it might be is guessing.

Q. So you do have an opinion, within a reasonable degree of medical certainty, as to what it's not?

A. That's right.

Q. And that is small cell and maybe a host of other different things?

A. Yeah. It's not -- it's clearly not a squamous cell because it has no squamous features, it's clearly not an adenocarcinoma because it has no adenocarcinoma features, it's clearly not a large cell undifferentiated --

THE COURT REPORTER: Slow down a little bit for me. I can't write that fast.

THE WITNESS: I'm too fast. All right.

A. It's clearly not a squamous cell -- it has none of the histologic features that would establish the diagnosis of squamous cell carcinoma, or adenocarcinoma, or large cell

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undifferentiated carcinoma, or small cell undifferentiated carcinoma. So of the common carcinomas, it has none of the histologic features that one would associate with that.

Q. And I assume, based on your expert witness disclosure, you also cannot say, based on a reasonable degree of medical certainty, that it is a carcinoid, either?

A. No, sir. That's right.

Q. And the next sentence, "Dr. Martin is of the opinion that for a definite diagnosis to be made of the specific type of neuroendocrine tumor, specialized knowledge and experience in the field of neuroendocrine tumors would be required." What types of specialized knowledge are you referring to?

A. Anyone that's seen more of this than I have. I've got -- well, medical centers, large medical centers tend to specialize in one area or another area, and there probably are centers that specialize on unusual tumors of the lung; i.e., perhaps neuroendocrine disorders. No one practicing pathologist will see a bunch of these. They just don't happen unless you attract the patients with this diagnosis to your facility.

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So there must be somewhere, somebody that has more knowledge of neuroendocrine tumors than I have. And there may be someone that has seen neuroendocrine tumors that had viable diagnostic elements in one area and necrotic elements looking like this in another area, to which you can say, oh, yes, this is what it looks like when it's viable, and this is what it looks like when it's necrotic. All we have is what it looks -- whatever it is as it looks necrotic.

So I'm presuming that there might be other people that have seen enough neuroendocrine tumors that may be able to draw conclusions that I'm not entitled to draw.

Q. Do you know -- or have specifically in mind any facility or one person?

A. No, sir, I do not.

Q. How many carcinoids have you diagnosed as a pathologist?

A. Anywhere in the body?

Q. Yes.

A. Lots of them.

Q. How many lung -- or carcinoids of the lung have you diagnosed?

A. I can't recall for certain. Most of

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the carcinoids that one would see would be from the appendix, and you would just simply stumble across them incidentally -- incidental to an appendectomy.

The other carcinoids would be occurring -- the most common carcinoids are those that occur in the gastrointestinal tract. But everybody knows they occur in the lung. And if it occurred in the lung and I got a piece of it, I would recognize it.

Q. They all look the same?

A. Yes, sir.

Q. Under the microscope.

A. If they're viable, you know, if they're viable. They have a -- they have a histologic pattern, and then you prove it with your special stains.

Q. To your recollection, have you ever seen a carcinoid of the lung?

A. I just -- I don't recall specifically.

Q. Okay.

MR. ESDALE: Can we take a break for a little bit? And I'll try to finish up.

MR. STUHAN: Yes.

(BREAK TAKEN.)

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EXAMINATION BY MR. ESDALE CONTINUED:

Q. Okay. Let's start with your handwritten notes --

A. Yes, sir.

Q. -- based on -- on the first slide, that S95-9068 --

A. Yes, sir.

Q. That is, my understanding, the biopsy?

A. That's the biopsy.

Q. The -- after the first dash there, it says, "lots of"? Am I reading that correctly?

A. Yes, lots of karyorrhexis.

Q. And I know you've mentioned that previously. What is karyorrhexis?

A. That's fragmentation of the nucleus.

Q. What does that look like under the microscope, as compared to a cell that does not have it?

A. It looks -- it looks like nuclei debris, you know, just -- if you were to take a glass ball and drop it on the concrete, it would shatter. It would look like shattered fragments of a nucleus.

Q. Okay. Then the next sentence says, "suggestion of nesting of cells"?

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A. Yes, sir.
Q. That is something you observed?
A. What I -- what I observed is the fact that there was a lot of stroma throughout this lesion and that there was clusters of necrotic cells scattered here, there, and yon. And that would be nesting.
Q. All separated by stroma?
A. Generally. It's an impression you get. Is it -- is it a wipe-out sheet, like a layer of skin, which would be, you know, sheets of cells? No, it's not that. Is it something that looks like clusters of cells separated by something? Yes, it looks like clusters of cells that are separated by stroma.
Q. Would it be fair to say that you saw cells in nests, but not in sheets?
A. There are no sheets of cells there, necrotic or otherwise. That was my point. It's trying -- it -- to me, it's showing residual of previous small nests of small cells and no residual of previous sheets of cells.
Q. Again, I'm not trying to be redundant here. "No good preservation of lesional cells," and I assume that's what you've been telling me

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about, none of them --

A. To my -- to my observation, the general picture was that of necrotic degenerated cells. And I didn't see any pattern of cells that looked like they were preserved enough for me to adequately evaluate them. It just looked like all of them -- all of them looked like they were necrotic in different ways. Not all of them had karyorrhexis. Some of them had pycnosis, and some of them just were smudgy, you know, you couldn't see the cytoplasm of the cells. And they just did not have good cytologic features that you would expect viable cells to have.

Q. When you say "smudgy," are you talking about the nuclei?

A. Just in -- yeah, just in distinct boundaries.

Q. And little cytoplasm?

A. Very little cytoplasm.

Q. You didn't see any samples that were preserved to make any type of diagnosis, preserved well enough --

A. Not of the -- not of the -- not of the lesional material. There were -- there were areas at one side that showed preserved bronchial

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epithelial lining. That's sitting there. You can see that very nicely. That's intact.

Q. Did you see any cilia?

A. Yeah.

Q. And is that something you would expect, one way or another, based on the biopsy, whether it was a small cell or a carcinoid, is that the epithelial cells would be present?

A. Usually. It depends on the -- it depends on the point in time in which the lesion is biopsied. It just so happens that all that does is says, yes, this came from someplace close to a bronchus, because it's got bronchial epithelial lining on it.

Q. And small cell lung carcinomas do occur centrally located next to the bronchus?

A. In the -- in the bronchial wall beneath the bronchial surface, yes.

Q. Do you have any opinions as to the size of this tumor?

A. Based on what they said it was. That's the only way you can come to an opinion, is what did the guy looking at it think it was? And he thought it was three to four millimeters.

Q. Is it common in your practice, whether

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it be a carcinoid or a small cell, that there would be more tumor than that visible through the bronchial wall or on the inside of the bronchial wall?

A. Small cell undifferentiated carcinomas would have an opportunity to become more extensive before it produced clinical symptoms. It usually does not occur as an itty-bitty little lesion. It's usually a more substantial pathologic process at the time of biopsy.

Endobronchial lesions, those that are growing from the surface of the bronchus into the lumen, can be of small size because they're not growing out into the lung. They're just growing into the cavity of the airway. They have an opportunity to manifest themselves sooner because, one, they're irritating the surface that produces a cough; and two, they can obstruct the bronchus to produce a pneumonia. So they're in a -- a little small lesion growing into the bronchial lumen can produce symptoms quicker than you would expect from a -- from a small cell undifferentiated carcinoma.

Q. And have you reviewed any of the radiology reports?

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A. I glanced at them, yes.

Q. Did you see anything that would indicate the size of the tumor based on the radiologist?

A. Radiologists can't judge the size of the tumor because they're looking at pneumonia. They can judge the size of the consolidation of the lung, but that's a -- that's a composite of the lesion and the obstruction of the bronchus producing the pneumonia. And we know that a lot of it is due to pneumonia. But I don't believe anybody established that the tumor was bigger than what was biopsied, because the pulmonologist said to himself, "I think we got it all." That was his words.

Q. Okay. So you believe that the entire size of the tumor was probably three to four millimeters?

A. That's the -- that's the only -- that's the only information of fact that we have.

Q. Again, I'm not trying to be redundant. I just want to make sure we're still talking about the same thing. You talked about surface epithelia were present and is intact, even an area of ciliated -- is that --

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A. Pseudostratified columnar.

Q. So that -- and that is what we were talking about, this ciliated -- the cilia you saw on that type of tissue?

A. That's the bronchial surface lining.

Q. The --

A. Now, it wasn't present everywhere. It's -- just was a little spot of it I could recognize.

Q. Could you orient this tumor from the base, going around the polypoid portion of it?

A. No, the only thing you can see is that it's pinched on one side, and rest of it's not pinched. That's all you can do.

Q. Okay.

A. By way of orienting.

Q. "Small lesional capillaries intact," is that what that says?

A. Yeah. It just -- it just says that I can recognize -- the cells that form the capillaries appear to be intact.

Q. Would they be -- and you're using the term "capillaries" --

A. The blood supply.

Q. Are they, by nature, small?

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A. Capillaries, by definition, are small.

Q. Are they -- can you have thick-walled capillaries, or are they thin-wall capillaries, or did you have any -- could you tell the size of the walls of the vessels?

A. These seem -- it's difficult to tell exactly what's wall and what's not wall. But where capillary lumens were identified, it looked like the surrounding tissue was thicker than thin.

Q. This --

A. The next one is--

Q. Is that cytology?

A. Yes.

Q. Can you describe to me what the occasional clumps of suspicious small-to-medium sized cells look like?

A. Yeah. They were just -- they were cells with -- that were the size of or slightly larger than the size of lymphocytes clumped up in blood, and, you know, they were not individual isolated cells that you could see in clean profile. It's just that there are chunks of cells that are something. They're suspicious for something present.

Q. Okay.

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A. But specifically to diagnose from that, no, I wouldn't make a diagnosis from that.

Q. Are they consistent -- I think you said earlier that they were two to three times the size of lymphocytes?

A. No, I say if they were going to be -- these were not -- these were not -- these were equal to or slightly larger than lymphocytes. These were not prominent, bigger; bigger cells. My comment earlier was that, by definition, the cells of small cell undifferentiated carcinoma are at least two to three times the size of lymphocytes.

Q. Do you have a -- or can you provide to me your opinion of what a small cell carcinoma would look like?

A. Well, I described it earlier, but I'll do it again. My -- the features, the pathology features upon which the diagnosis of small cell undifferentiated carcinoma depend are as follows: The cells are small, but there will be of size -- nuclear size two to three times that of a mature lymphocyte. The cells will have stippled hyperchromatic nuclei. They may be round, or they may be ovaled -- oval and tapered. The cytoplasm

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will be scanty. So those are the cellular features of a small cell undifferentiated carcinoma.

The tumor cells occur in sheets that irregularly and haphazardly infiltrate the tissue, but they occur in broad or irregular sheets of tumor cells. They don't tend to nest except as sheets of cells irregular infiltrate surrounding stroma, because the ever rapidly growing tumor they have the capacity to outgrow their blood supply so that large areas of necrosis can and do occur, but they occur in large areas and don't wipe out the entire tumor. You can't diagnose a tumor unless you can see viable sheets of cells that I just described.

The other feature of this lesion that occurs as incidental to obtaining the biopsy is that the cells are soft and tend to be compressible, so you can get a compression artifact. All that does is says look hard for intact cells, because you might be dealing with a small cell undifferentiated carcinoma. But you don't establish the diagnosis based on crush artifact or necrosis. But it will occur as irregular sheets infiltrating tumor.

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Q. Were there any mitotic figures in the cytology or the biopsy?

A. These cells are dead. I didn't see any mitoses.

Q. None at all?

A. Not that I observed.

Q. Would you expect to be able to see the capillaries in a small cell carcinoma, even in the areas of necrosis?

A. Oh, yeah. Oftentimes, in the areas of necrosis, the small blood vessels in there will be encrusted with nuclear debris. So even though the rest of the background is necrotic tissue, you can see the outlines of blood vessels because they have adhered to them, the residue of nuclear debris from the previous tumor. None of which is present in this, but, I mean, you can see capillaries in the necrotic area, or you might not see them in the necrotic area.

Q. You didn't see any DNA encrusted --

A. No.

Q. -- blood vessels?

A. No, sir.

Q. Are there -- did you see any significantly inflamed cells in the biopsy?

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A. I don't -- I don't recall significant inflammation, but there might have been there.

Q. If there was, it wasn't significant enough to stand out in your mind?

A. It was not what -- well, it -- I didn't describe it.

Q. Okay.

A. So I don't -- I mean, I really don't know. I'm not -- I was not struck by any inflammatory process being present. It might have been there, but, I mean, it was not --

Q. Does the term "encephaloid tumor" mean anything to you?

A. Encephaloid tumor? I don't -- I don't know what will be called an encephaloid tumor, except that the term, itself, means that it has the shape of a brain or, knotty shape encephaloid, but I don't know what it would be referring to.

Q. All right. Would you consider the necrosis in the biopsy that you viewed to be geographic in nature?

A. No, sir. That was the point I was trying to make. It just doesn't show the geographic destruction of tumor that would be one of the findings that you would associate over --

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would find with small cell undifferentiated carcinoma and would be the usual and expected necrotic presentation of the tumor. It's just -- it's not present in this biopsy.

MR. ESDALE: Okay.

MR. STUHAN: Is that it?

MR. ESDALE: I believe so. Give me one second.

(DISCUSSION OFF THE RECORD.)

MR. ESDALE: I don't think I've got anything else.

(The deposition was concluded at 11:15 a.m.)

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SIGNATURE OF WITNESS

I, _____, do solemnly swear that I have read the foregoing pages and that the same is a true and correct transcript of the testimony given by me at the time and place hereinbefore set forth, with the following corrections:

PAGE:	LINE:	SHOULD READ:	REASON FOR CHANGE:
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(SIGNATURE)

NOTARIZATION

I, _____, notary public for the State of _____, _____ County, do hereby certify that _____ personally appeared before me this _____ day of _____, 1999, at _____, _____.

My Commission Expires:

_____ _____

(NOTARY PUBLIC)

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CERTIFICATE OF COURT REPORTER

I, Melissa L. Burnham, CSR/RPR, and Notary Public in and for the County of Rankin, State of Mississippi, hereby certify that the foregoing pages, and including this page, contain a true and correct transcript of the testimony of the witness, as taken by me at the time and place heretofore stated, and later reduced to typewritten form by computer-aided transcription under my supervision and to the best of my skill and ability.

I further certify that I placed the witness under oath to truthfully answer the questions in this matter under the power vested in me by the State of Mississippi.

I further certify that I am not in the employ of or related to any counsel or party in this matter, and have no interest, monetary or otherwise, in the final outcome of the proceedings.

Witness my signature and seal this the 2 day of March, 1999.

M L Burnham

MELISSA L. BURNHAM, CSR/RPR
My Commission Expires April 4, 2000

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IN THE CIRCUIT COURT FOR
SUMTER COUNTY, ALABAMA

JIMMY C. ACTON, Plaintiff, vs. R. J. REYNOLDS TOBACCO COMPANY; et al., Defendants.	CIVIL ACTION NUMBER: CV-96-98

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NOTICE OF TAKING DEPOSITION

Please take notice that, pursuant to the Alabama Rules of Civil Procedure, Plaintiff will take the deposition of Arthur M. Martin, M.D., as an expert witness to be called at the trial of this case, upon oral examination before an officer authorized by law to administer oaths.

DEPONENT: Arthur M. Martin, M.D.

DATE: February 10, 1999

TIME: 9:00 a.m. / CST

PLACE: Meridian, Mississippi
Exact Location to be Determined

The matters on which examination is required and the documents to be produced at the deposition are:

1. Testimony and documents evidencing or relating to any and all documents, correspondence, reports, medical reports, photographs, standards, charts, memos or writings of any kind reviewed by said expert in preparing for this case.

2. Testimony and documents evidencing or relating to any and all documents, correspondence, reports, charts, memos, photographs, measurements, drawings, blueprints, video tapes, or writings of any kind that said expert has relied on in forming opinions and conclusions in this case.

3. Testimony and documents relating to any and all opinions of said expert in this case, including any reports, memoranda, documents, notes and/or writings of any kind whatsoever reflecting this expert's opinions in this case.

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4. Testimony and documents evidencing or relating to the said expert's education, background, experience, qualifications and services, including, but not limited to, a copy of this expert's resume.

5. Testimony and documents evidencing or relating to any and all lawsuits or claims in which said expert has been consulted and/or testified. This should include, but not be limited to, the name of the plaintiff, the name of the defendant, the court where the action was brought and the civil action number.

6. Each and every item of correspondence, memo or other document in this expert's file.

7. Each and every memo, item of correspondence, document or any other item sent from any of the attorneys for the defendant to this expert.

8. A complete list of each and every lawsuit or case this expert has done any consulting work in. This should include, but not be limited to, the attorney whom this expert was working for, civil action number, state and county in which the suit was filed and a brief summary about the facts of the case.

9. Testimony and documents evidencing or relating to all contracts or writings confirming deponents employment in this case.

10. Testimony and documents evidencing or relating to all reports, writings, memoranda, handwritten notes in any form, and any other notes deponent has made, whether handwritten or recorded by audio/visual means, related to this case.

11. Testimony and documents evidencing or relating to all hour sheets or bills.

12. Testimony and documents evidencing or relating to all depositions or summaries of depositions provided to deponent for review in this case.

13. Testimony and documents evidencing or relating to all articles written by deponent on any issue involved in deponent's testimony.

14. All prior depositions given by this deponent on similar issues.

R. GRAHAM ESDALE, JR. (ESD002)
Attorney for Plaintiff

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CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of the foregoing document upon all counsel of record as listed below by facsimile transmission and by placing a copy of same in the United States Mail, first class, postage prepaid on this the 8th day of February, 1999.

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IN THE CIRCUIT COURT FOR SUMTER COUNTY, ALABAMA

JIMMY C. ACTON,	)	
	)	
Plaintiff,	)	
	)	CIVIL ACTION NO.
vs.	)	
	)	CV-96-98
R.J. REYNOLDS TOBACCO COMPANY, et al.,	)	
	)	
	)	
Defendants.	)	

DEFENDANTS' EXPERT WITNESS DISCLOSURE OF ARTHUR M. MARTIN, JR., M.D.

Dr. Arthur M. Martin Jr. is a medical doctor and Board certified pathologist. He received his medical degree from Duke University in 1961, and completed his Residency in Pathology at Duke University in 1965. Dr. Martin is licensed to practice medicine in North Carolina, Mississippi and Alabama. Dr. Martin's medical practice is located at Rush Hospital-Meridian, in Meridian, Mississippi. A copy of Dr. Arthur M. Martin Jr.'s curriculum vitae is attached hereto.

Dr. Martin will be offered as an expert in the fields of pathology and medicine as they relate to the role of a pathologist in the diagnosis of benign and malignant tumors. Dr. Martin will also offer his expert opinions on the diagnosis in the medical records of Mr. Acton's tumor. Dr. Martin may also be called upon to comment on matters raised in the testimony of other witnesses as they relate to his area of expertise.

Dr. Martin will testify regarding the techniques, procedures and criteria used by medical practitioners in pathology to diagnose diseases, including cancer. Dr. Martin will testify that lung cancer is not one disease, and the term lung cancer is sometimes used to describe any one of several

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kinds of malignant tumors. It is Dr. Martin's opinion that Mr. Acton's lung tumor exhibits neuroendocrine characteristics. Neuroendocrine growths cover the spectrum from benign carcinoids to malignant small cell carcinomas. Dr. Martin is of the opinion that Mr. Acton's clinical course is inconsistent with a diagnosis of small cell lung cancer.

Based on the available material, the medical history, clinical course, and his own experience and expertise, Dr. Martin would not draw a conclusion as to the specific type of neuroendocrine tumor found in Mr. Acton's lung. Dr. Martin is of the opinion that for a definite diagnosis to be made of the specific type of neuroendocrine tumor, specialized knowledge and experience in the field of neuroendocrine tumors would be required.

Dr. Martin bases his opinions on his education, training and experience, research and publications, his review of the pertinent scientific and medical literature reasonably relied upon by other members of his profession, the medical records made available to him, pathologic materials, witness statements in this proceeding, and other information about Mr. Acton.

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CURRICULUM VITAE

Name: Arthur Morrison Martin, Jr. U.S. Citizen
Male

Date and Place of Birth: November 26, 1934
Savannah, Georgia

Married - Jacquelyn Harris Martin

EDUCATION:

College: Davidson College, Davidson, N.C., 1952-1956, B.S. Degree, cum laude.
Graduate: Duke University, Durham, N.C., 1956-1958, and 1959-1961, M.D. Degree (Medical)

POSITIONS HELD:

Duke University Medical Center, Research Fellow in Medicine, 1958-1959.
Duke University Medical Center, Intern in Pathology, 1961-1962.
Duke University Medical Center, Resident in Pathology, 1962-1965.
Duke University Medical Center, Associate in Pathology, 1965-1966.
Walter Reed Army Institute of Research, Chief, Surgical Pathology, 1966-1968.
Duke University Medical Center, Assistant Professor of Pathology, (July, 1968-October, 1969).
Columbia (S.C.) Hospital, Director of Laboratories, 1969-1970.
The Memorial Hospital, Danville, VA, Resident in Pathology, 1970-1971.
The Memorial Hospital, Danville, VA, Staff Pathologist, 1970-1978.
Rush Medical Group and Rush Foundation Hospital, Meridian, MS, Director of Laboratories, 1979-1987; Active Staff; 1978-present.
T.C. Riley Memorial Hospital, Meridian, MS, Courtesy Staff, 1980-
Meridian Regional Hospital, Meridian, MS, Courtesy Staff, 1980-1988.
Rush Hospital-Butler, Butler, AL, Consulting Staff, 1980-1993.
Rush Hospital-Newton, Newton, MS, Consulting Staff, 1980-1994.
University of South Alabama, Clinical Asso. Professor, Pathology, 1985-
Rush Hospital-Meridian, MS, Credentials Committee, 1986-; Chairman, 1995-

MILITARY SERVICE:

Captain, Medical Corps, U.S. Army, July, 1966 - July, 1968.

ACADEMIC AND PROFESSIONAL HONORS:

Phi Beta Kappa, 1956.
Alpha Omega Alpha, 1960.
Baker Scholar, Davidson College, 1952-1956.
USPHS post-sophomore fellow, 1958-1959.
USPHS post-doctoral fellow, 1961-1964.
Research Fellow in Pathology, Duke University Medical Center, 1964-1965.
Diplomate, American Board of Pathology, 1966 PA, 1972 CP, 1975 RIP.
USPHS Career Development Award, 1968.

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CURRICULUM VITAE
Dr. Arthur M. Martin, Jr.

PROFESSIONAL SOCIETIES:

College of American Pathologists, 1970-
American Association of Pathologists and Bacteriologists, 1966-1978.
Sigma XI, 1964-
Danville-Pittsylvania Academy of Medicine, 1970-1978; sec-treas., 1971-1973.
Virginia Society for Pathologists, 1971-1978.
Medical Society of Virginia, 1971-1978.
American Society of Clinical Pathologists, 1971-
Mississippi State Medical Association, 1978-
East Mississippi Medical Society, 1978-
Tri-State Pathology, 1979-
Mississippi Association of Pathologists, 1980-
American Medical Association, 1986-

MEDICAL LICENSURE:

Active: North Carolina, Mississippi, Alabama

COMMUNITY ACTIVITIES:

Board Member, Danville Cancer Association, 1971-1977.
United Fund, Budget and Planning Committee, 1974-1977.
Professional Advisory Committee, Danville-Pittsylvania Mental Health Association, 1974-1977.
Advisory Committee, Fisheries Division, VPI & SU, 1974-1977.
Clinical Faculty, Meridian (MS) Junior College, Medical Laboratory Technician Program (Medical Director), Dental Hygienist Program (Instructor), 1979-
Member, Greater Meridian Chamber of Commerce, 1978-
Member, Lauderdale County Heart Asso., 1980-

Author or co-author of 26 scientific articles.

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ARTHUR M. MARTIN, JR., M.D.

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2. Martin, A. M., Jr., Hackel, D. B., and Kurtz, S. M. The ultrastructure of zonal lesions of the myocardium in hemorrhagic shock. Am. J. Path. 1964, 44, 127.

3. Hackel, D. B., Martin, A. M., Jr., Spach, M., and Sieker, H. O. Hemorrhagic shock in dogs: Relation of hemodynamic and metabolic changes to myocardial lesions. Arch. Path. 1964, 77, 575.

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18. Martin, A.M., Jr., Greene, W.B., Soloway, H.B., and Simmons, R.L. Human myocardial zonal lesions. Arch. Path., March, 1969, 87, 339-342.

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22. Simmons, R.L., Heisterkamp, C.A., III, Collins, J.A., Gensler, S., and Martin, A.M., Jr. Respiratory insufficiency in combat casualties. III. Arterial Hypoxemia after wounding. Ann. Surg., July, 1969, 170, 45-52.

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A.M. Martin, Jr.

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Tom Vumbacco
Shook Hardy

Acton v. Tobacco
RJR Raw

11/17/91

Non-smoker, male, married
wife - smoker
DOB - 1/34

Jimmy Acton - ca lung
64 yo WM

Cardiologist - Kirkland Clinic - Peterman
Druid City Med Ctr
Dr Holifield in

initial Dx - Small Cell Ca 4/95 - prior X-ray - RLL mass confirmed by CT Scan mass 4.5 cm
- alive and improving today
Bone scan - negative (round lobulated mass)
Bx - Dr. Perot in Demopolis - lung
- bronchoscopy - 3-4 mm in bronchial tube - ? Viral papilloma.
Biopsy to Boris Dotrow (pathologist)
Poorly diff Ca - Oat cell
Radiation + Chemo Rx completed June 1995
Dec 1995 - Bone scan ? increased uptake rib 5-7 lateral
MDs predict mortality - Radiation therapy
Repeat Bone Scan also CT 5/96 - 9/97 - normal clear
Maintains chronic cough
at present approx 2/3 rds R lung functional.

Twice for CABG - complications
C.A. Bypass surg - angioplasty
Diagnosis: Coronary Heart

wife 6 cig/day around husband
Jimmy stated cigarette smoke
- most associates would not smoke in Jimmy's presence due to his cardiac condition
- prior injury to right lower chest and

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EXHIBIT #3 Martin PENGAD-Bayonne N.J.

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SPA INC

595-9068

Small fragments markedly necrotic scant cellular lesion - lots of karyorrhexis - suggestion of fusing of cells - no good preservation of lesional cells - surface epithelium where present is intact - even area of ciliated pseudostratified columnar. Small lesional capillaries intact

SPA INC Cytol 95-5845

blood and occasional clumps of suspicious small to medium sized cells. Not clear cut.

Cannot clearly establish diagnosis based on available material. Course of action.

1- request repeat bx

2- do immunohistochemicals re LCA, chromogranin CK, Chromosin, etc

3- refer to Mayo, etc.

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BRYAN WHITFIELD MEMORIAL HOSPITAL
DEMOPOLIS, ALABAMA

REPORT OF OPERATION

4-10

NAME: ACTON, JIMMY
PATIENT #: 951210
ROOM : 329B
DOCTOR: HOLIFIELD AND PERRET

Date of Operation: 4-10-95

Pre-Operative Diagnosis: UNEXPLAINED LESION OF RIGHT LOWER POSTERIOR LUNG FIELD.

Post-Operative Diagnosis: LESION IN THE BRONCHIAL TUBE WHICH LOOKS LIKE A VIRAL PAPILLOMA. THE LESION MEASURES 3-4 MM AT THE MOST AND ALTHOUGH I HAVE SEEN CANCER LOOK LIKE THIS IT IS MIGHTY SMALL AND I AM PRETTY SURE WE WILL BE ABLE TO GET IT ALL OUT OF THERE IF INDEED IT IS A MITOSIS. WE SENT BIOPSIES AND WILL TREAT ACCORDINGLY.

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BRYAN W. WHITFIELD MEMORIAL HOSPITAL
DEMOPOLIS, ALABAMA

Procedure: BRONCHOSCOPY

Surgeon: PERRET
Assistant:

Findings and Procedure:

THE PROCEDURE, OPTIONS, RISKS, AND COMPLICATIONS HAVE BEEN EXPLAINED IN DETAIL WITH UNDERSTANDING AND DESIRE TO PROCEED.

BRONCHOSCOPE WAS PASSED UNDER DIRECT VISION AFTER TOPICAL NASAL AND ORAL LIDOCAINE ANESTHESIA. 75 OF DEMEROL WAS USED AND 1.5 OF VERSED. THE PROCEDURE TOOK ABOUT 45 MINUTES BECAUSE WE BIOPSIED A LESION. THE BRONCHOSCOPE WAS PASSED UNDER DIRECT VISION THROUGH THE MOUTH BECAUSE OF SEPTAL DEVIATION OF THE NOSE. GOT A GOOD LOOK AT THE LARYNX HERE THROUGH THE MOUTH AND ANESTHETIZED THE LARYNX WITH TOPICAL LIDOCAINE. SCOPE WAS THEN PASSED AFTER NOTING GOOD ANESTHESIA AND STARTED CHOKING SO WE REMOVED THE SCOPE AND THEN PUT MORE ANESTHESIA ON THE CORDS AND GAVE ANOTHER 25 DEMEROL FOR A TOTAL OF 75, HE WAS GIVEN INITIALLY 50 AND 1 MG OF VERSED. GAVE HIM ALSO ANOTHER .5 MG OF VERSED. WE ANESTHETIZED THE LARYNX AND PASSED THE SCOPE WITHOUT DIFFICULTY. WE WENT DOWN THE RIGHT SIDE FIRST AND EVERYTHING LOOKED NORMAL EXCEPT THE RIGHT POSTERIOR ANTERIOR LOBULE HAD A VIRAL PAPILLOMATOUS LOOKING LESION ALMOST COMPLETELY OCCLUDING IT. WE BIOPSIED THIS TIMES 2 AND DID A BRUSH BIOPSY OF THAT. THE REST OF THE BRONCHOSCOPY WHICH INCLUDED THE LEFT SIDE AS WELL WAS NORMAL.

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BRYAN WHITFIELD MEMORIAL HOSPITAL
DEMOPOLIS, ALABAMA

REPORT OF OPERATION

NAME: ACTON, JIMMY
PATIENT #: 951210
ROOM :
DOCTOR: HOLIFIELD AND PERRET

Norbert E. Perret, M.D.

NEP\ekm
DICT: 4-10-95
TRANS: 04/10/95 @ 12:34 P.M.

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BRYAN W. WHITFIELD MEMORIAL HOSPITAL
DEMOPOLIS, ALABAMA

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